

TARGETED CASE MANAGEMENT SERVICES

A. TARGET GROUP

1. Intellectually/Developmentally Disabled

The population to be served consists of individuals who meet diagnostic criteria according to the most current Diagnostic and Statistical Manual of Mental Disorders for mental retardation and/or the definition of developmental disability as "a severe, chronic disability of a person which: (1) is attributable to a mental or physical impairment or a combination of mental and physical impairments; (2) is manifested before the person attains age twenty-two; (3) results in substantial functional limitations in three or more of the following areas of major life activity: (A) Self-care; (B) receptive and expressive language; (C) learning; (D) mobility; (E) self-direction; (F) capacity for independent living; and (G) economic self-sufficiency; (4) Reflects the person's need for services and supports which are of lifelong or extended duration and are individually planned and coordinated."

Medical necessity for case management services will include a determination that individuals demonstrate substantial functional limitations in two (2) major life areas (see item 3, paragraph 1) as determined by an assessment appropriate to the individual being assessed. Recipients must be reassessed at scheduled intervals for functional limitation status in order to-determine continuing medical need.

Recipients qualifying for Targeted Case Management must be currently living in the community or within 60 days of placement in the community through discharge planning from a Medicaid-certified facility.

E. DEFINITION OF SERVICES

Targeted case management services are those services which will assist Medicaid-eligible recipients in the target group to gain access to needed medical, social, educational and other services.

The core elements of targeted case management shall include the following:

1. Assessment and Reassessment: Reviewing of the individual's current and potential strengths, resources, deficits and need for medical, social, educational and other services. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual. The targeted case manager ensures an on-going formal and informal process to collect and interpret information about a member's strengths, needs, resources, and life goals at a minimum, an annual face-to-face reassessment shall be conducted to determine if the client's needs or preferences have changed. This process is to be used in the development of an individualized service plan. Assessment is a collaborative process between the member, his/her family, and the targeted case manager.

2. Linkage, Referral, Advocacy and Related Activities: Facilitating the individual's access to the care, services and resources through linkage, coordination, referral, consultation, and monitoring. This is accomplished through in-person and telephone contacts with the individual, his or her parent(s) or legal guardian, and with service providers and other collaterals on behalf of the individual. This will occur as necessary, but at least annually. This may include facilitating communication between the individual, his or her parent(s) or legal guardian and the targeted case manager and between the individual, his or her parent(s) or legal guardian and other service providers; It also includes advocating for the individual in matters regarding access, appropriateness and proper utilization of services; and evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific individual. This may also include acquainting the individual, his or her parent(s) or legal guardian with resources in the community and providing information for obtaining services through community programs.

3. Development and Revision of the Service Plan: The case manager ensures and facilitates the development of a comprehensive, individualized service plan. The service plan records the full range of services, treatment, and/or other support needs necessary to meet the member's goals. The case manager is responsible for regular service planning reviews based on the member's needs at regularly scheduled intervals. (Note: When the case manager participates in a service plan meeting, the services provided are not billable as Targeted Case Management.) Developing a written plan based on the assessment of strengths and needs, which identifies the activities and assistance needed to accomplish the goals collaboratively developed by the individual, his or her parents(s) or legal guardian, and the targeted case manager. Development (and periodic revision) of the Service Plan will specify the goals and actions to address the services needed by the eligible individual. The service plan describes the nature, frequency, and duration of the activities and assistance that meet the individual's needs.

4. Monitoring and Follow-up Activities: The targeted case manager shall conduct regular monitoring and follow-up activities with the client, the client's legal representative, or with other related service providers. Monitoring will be done to ensure that services are being furnished in accordance with the individual's Service Plan. Periodic review of the progress the individual has made on the service plan goals and objectives and the appropriateness and effectiveness of the services being provided on a periodic basis. This review may result in revision or continuation of the plan, or termination of Targeted Case Management services if they are no longer appropriate. Periodic reviews may be done through personal and telephone contacts with the individual and other involved parties. The periodic reviews will be conducted as necessary but at least annually. The Targeted Case Manager ensures appropriate quality, quantity and effectiveness of service in accordance with the Service Plan. The Targeted Case Manager may only utilize and bill for this component when one of the above stated components have been utilized and determined to be a valid TCM activity. The amount of time spent to "monitor/follow-up" a TCM service shall not exceed the amount of time spent rendering the valid activity.

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E. PROVIDER QUALIFICATIONS

The option to restrict providers for the Intellectually/Developmentally Disabled is not being exercised under Targeted Case Management.

A provider of Targeted Case Management Services to the Intellectually/Developmentally Disabled must hold licensure as a behavioral health agency pursuant to 27-2A-I of the West Virginia Code. Providers must demonstrate a capacity to provide targeted case management services through a comprehensive provider agreement. This agreement requires 24-hour service availability by the provider and stipulates that the recipient's freedom of choice must be assured by the provider. It also requires the following:

- 1) Demonstrated capacity to link recipients in the target group(s) to a comprehensive array of services.
- 2) Assurance that agency staff are sufficient in number and appropriately qualified through training and experience to address the needs of the target population(s) served.
- 3) An administrative capacity to ensure quality of services; documentation of services; and maintenance of individual records in accordance with state and federal requirements.
- 4) The financial management capacity to document services and prepare and submit claims for these services.
- 5) Assure through the client enrollment process that all recipients are informed that recipients may choose from available certified case management providers.

Providers must assure that all staff providing targeted case management services possess one of the following qualifications:

- a) A licensed psychologist with a Masters or Doctoral degree;
- b) A licensed social worker;
- c) A registered nurse; or
- d) A Doctorate, Masters or Bachelor's degree in Human Services Field.

A. TARGET GROUP

2. Chronically Mentally Ill/Substance Abuse

The population to be served consists of individuals who meet diagnostic criteria according to the most current Diagnostic and Statistical Manual of Mental Disorders for chronic mental illness or substance abuse.

Medical necessity for case management services will include a determination that individuals demonstrate substantial functional limitations in two (2) major life areas as determined by a State-approved standardized assessment instrument(s) appropriate to the individual being assessed. Major life areas include: vocational, education, homemaker, social or interpersonal, community, and self-care or independent living. Individuals must be reassessed at scheduled intervals at a minimum for functional limitation status in order to determine continuing medical need.

Recipients qualifying for Targeted Case Management must be currently living in the community or within 60 days of placement in the community through discharge planning from a Medicaid-certified facility.

D. DEFINITION OF SERVICES

Case management services are those services which will assist Medicaid-eligible recipients in the target group to gain access to needed medical, social, educational and other services.

The core elements of targeted case management shall include the following:

1. Assessment and Reassessment: Reviewing of the individual's current and potential strengths, resources, deficits and need for medical, social, educational and other services. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual. The targeted case manager ensures an on-going formal and informal process to collect and interpret information about a member's strengths, needs, resources, and life goals at a minimum, an annual face-to-face reassessment shall be conducted to determine if the client's needs or preferences have changed. This process is to be used in the development of an individualized service plan. Assessment is a collaborative process between the member, his/her family, and the targeted case manager.

2. Linkage, Referral, Advocacy and Related Activities: Facilitating the individual's access to the care, services and resources through linkage, coordination, referral, consultation, and monitoring. This is accomplished through in-person and telephone contacts with the individual, his or her parent(s) or legal guardian, and with service providers and other collaterals on behalf of the individual. This will occur as necessary, but at least annually. This may include facilitating communication between the individual, his or her parent(s) or legal guardian and the targeted case manager and between the individual, his or her parent(s) or legal guardian and other service providers; It also includes advocating for the individual in matters regarding access, appropriateness and proper utilization of services; and evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific individual. This may also include acquainting the individual, his or her parent(s) or legal guardian with resources in the community and providing information for obtaining services through community programs.

3. Development and Revision of the Service Plan: The case manager ensures and facilitates the development of a comprehensive, individualized service plan. The service plan records the full range of services, treatment, and/or other support needs necessary to meet the member's goals. The case manager is responsible for regular service planning reviews based on the member's needs at regularly scheduled intervals. (Note: When the case manager participates in a service plan meeting, the services provided are not billable as Targeted Case Management.) Developing a written plan based on the assessment of strengths and needs, which identifies the activities and assistance needed to accomplish the goals collaboratively developed by the individual, his or her parents(s) or legal guardian, and the targeted case manager. Development (and periodic revision) of the Service Plan will specify the goals and actions to address the services needed by the eligible individual. The service plan describes the nature, frequency, and duration of the activities and assistance that meet the individual's needs.

4. Monitoring and Follow-up Activities: The targeted case manager shall conduct regular monitoring and follow-up activities with the client, the client's legal representative, or with other related service providers. Monitoring will be done to ensure that services are being furnished in accordance with the individual's Service Plan. Periodic review of the progress the individual has made on the service plan goals and objectives and the appropriateness and effectiveness of the services being provided on a periodic basis. This review may result in revision or continuation of the plan, or termination of Targeted Case Management services if they are no longer appropriate. Periodic reviews may be done through personal and telephone contacts with the individual and other involved parties. The periodic reviews will be conducted as necessary but at least annually. The Targeted Case Manager ensures appropriate quality, quantity and effectiveness of service in accordance with the Service Plan. The Targeted Case Manager may only utilize and bill for this component when one of the above stated components have been utilized and determined to be a valid TCM activity. The amount of time spent to "monitor/follow-up" a TCM service shall not exceed the amount of time spent rendering the valid activity.

E. PROVIDER QUALIFICATIONS

The option to restrict providers for the Chronically Mentally Ill and Substance Abuse population is not being exercised under Targeted Case Management.

A provider of Targeted Case Management Services to the Chronically Mentally Ill and Substance Abuse must hold licensure as a behavioral health agency pursuant to 27-2.A-1 of the West Virginia Code. Providers must demonstrate a capacity to provide targeted case management services through a comprehensive provider agreement. This agreement requires 24-hour service availability by the provider and stipulates that the recipient's freedom of choice must be assured by the provider. It also requires the following;

- I) Demonstrated capacity to link recipients in the target group(s) to a comprehensive array of services.
- 2) Assurance that agency staff are sufficient in number and appropriately qualified through training and experience to address the needs of the target population(s) served.
- 3) An administrative capacity to ensure quality of services; documentation of services; and maintenance of individual records in accordance with state and federal requirements.
- 4) The financial management capacity to document services and prepare and submit claims for these services.
- 5) Assure through the client enrollment process that all recipients are informed that recipients may choose from available certified case management providers.

Providers must assure that all staff providing targeted case management services possess one of the following qualifications:

- a) A licensed psychologist with a Masters or Doctoral degree;
- b) A licensed social worker;
- c) A registered nurse; or
- d) A Doctorate, Masters or Bachelor's degree in Human Services Field.